DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/09/16

PRINTED: 05/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING 01 - MAIN BUILDING A B. WING ______	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide labeled fire doors in the stairwells. The findings include: Observation on 5/25/16 at 10:15 AM and 10:45 AM revealed doors on the 3rd floor and 1st floor protecting the center stairwell are not labeled fire doors. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/25/16.	K 021	**Corrective Actions for Targeted Residents** On 5-26-16, the Maintenance Director contacted Trimble door to replace the 3rd floor and 1st floor center stairwell doors to a labeled fire door. The installation will be complete by 7-8-16. **Identification of Other Residents with Potential to be Affected** On 5-26-16, the Maintenance Director inspected facility fire doors and found no other areas affected. **Systematic Changes** Measures to assure compliance include a quarterly audit of fire doors by the Maintenance Director to ensure that they have proper labeling and that labels have not been painted over. **Monitoring** Results of these audits will be reported quarterly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for Review and Recommendations. The Assistant Administrator and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. Continue	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 6-8-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 021 SS=E	Continued	K 021	Monitoring (Continued) The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	7/8/16

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	445469	A. BUILDING 03 - 1994 ADDITION B. WING ____	05/25/2016

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K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to have walls to hazardous rooms resist the passage of smoke. The findings include: Observation on 5/25/16 at 11:07 AM and 1:22 PM revealed a louvered opening in the walls of the storage room in the therapy's department office and the housekeeping closet in the "A" Buildings staff lounge. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/25/16.	K 029	**Corrective Actions for Targeted Residents** On 6-10-16, Allied Metals sealed the louvered openings to resist the passage of smoke, located in the walls of the storage room in therapy's office and housekeeping's closet in "A" building staff lounge. **Identification of Other Residents with Potential to be Affected** On 5-31-16, the Maintenance Director inspected the facility hazardous storage rooms for openings that would not resist the passage of smoke and did not find any areas affected. **Systematic Changes** Measures to assure compliance include a quarterly audit of hazardous storage rooms by the Maintenance Director to ensure that walls would resist the passage of smoke. **Monitoring** Results of these audits will be reported quarterly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for Review and Recommendations. Continue	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Carver DeLoach TITLE: Administrator (X6) DATE: 6-8-16

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K 029	Continued	K 029	Monitoring (Continued) The Assistant Administrator and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	7/8/16

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	445469	A. BUILDING 09 - 1994 ADDITION B. WING	05/25/2016

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K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain fire rated doors. The findings include: Observation on 5/25/16 at 1:04 PM revealed the cross corridor fire doors by room 407, the lower latch was not working and protruding into the floor strike. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference. NFPA 101 2000 Edition - 19.7.6 - 4.6.12 - NFPA 80 2-4.1.4*, 2-5.2	K 130	<u>Corrective Actions for Targeted Residents</u> On 5-26-16, the Maintenance Director contacted Trimble Door Company to repair the latch of the cross corridor fire doors by room 407. Trimble will install a UL rated fire stop pin to secure the lower portion of the door during a fire. The repair will be completed by 7-8-16. <u>Identification of Other Residents with Potential to be Affected</u> On 5-26-16, the Maintenance Director inspected facility cross corridor fire doors latches for the proper operation and found they were working as designed. <u>Systematic Changes</u> Measures to assure compliance include a quarterly audit of cross corridor fire doors by the Maintenance Director to ensure that latching hardware is operating correctly and compliance with NFPA 101 and NFPA 80.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Carmen DeLoach	Administrator	6-8-16

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K 130 SS=D	Continued	K 130	<u>Monitoring</u> Results of these audits will be reported quarterly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for Review and Recommendations. The Assistant Administrator and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	7/8/16